VOLUNTARY TERMINATION FORM

EMPLOYEE SOCIAL SECURITY NUMBER _____

EMPLOYEE FIRST & LAST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

I WISH TO TERMINATE THE FOLLOWING VOLUNTARY PROGRAMS:

- ☐ ***Basic Dependent Life***
- ☐ ***AD&D***
- ☐ ***Short Term Disability***
- ☐ ***Supplemental Life-EE***
- ☐ ***Long Term Disability***
- ☐ ***Supplemental Life-Spouse***
- ☐ ***Cancer Insurance***
- ☐ ***Supplemental Life-Child***
- ☐ ***Major Illness***
- ☐ ***Long Term Care: Employee***
- ☐ ***Vision***
- ☐ ***Long Term Care: Dependent***

____Dependent ___Spouse ___All Coverage

When terming dependent coverage for **Vision or Long Term Care**, list the name(s) and dates of birth for the dependents you are terming coverage.

_____

Qualifying Event & Date:

Divorce_____ ***Death_____***

Loss of Eligibility_____ ***Other_____***

Documentation of a qualifying event must accompany this form for termination of voluntary benefits. Termination during the annual open enrollment period does not required supporting documentation.

Employee Signature:_____ Date:_____

2/8/07